STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 16, 17, 18, 19, and 20, 2011 Facility number: 000389 Provider number: 15E245 AIM number: 100288920 Survey team: Diana Zgonc RN TC Christi Davidson RN Courtney Hamilton RN Suzanne Williams RN Connie Landman RN Census bed type: NF: 36 Total: 36 Census payor type: Medicaid: 35 Other: 1 Total: 36 Stage 2 sample: 11 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 5-24-11 Cathy Emswiller RN			
F0226 SS=C	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure its abuse prohibition policy and procedure included the requirement to immediately notify the Administrator of allegations of mistreatment, abuse, neglect and injuries of unknown source, and included specific guidelines for the investigating and reporting injuries of unknown source. This had the potential to affect all 36 residents residing in the facility. Findings include: Review of the Abuse Prohibition, Reporting and Investigation of Resident Abuse, Neglect and Mistreatment policy and procedure, dated 7/2005, and revised 10/2006 and 7/2009, and identified as the current policy by the Director of Nursing, indicated the following under "Identification and Reporting of Suspected Abuse, Neglect and Mistreatment": "1. ...must be reported immediately to	F0226	The policy and procedure that failed to state that the Administrator would be the first to be notified in article 1,2 and 3 under identification and reporting of suspected abuse, neglect and mistreatment now put the Administrator first and the other supervisors after the Administrator. The above changes will be given to each employee and they will sign the appropriate sheet stating they recognize the change in policy and procedure. When a bruise is noted on a resident and their is question on the incident causing the bruise it will be noted if the resident is on any blood thinner medication, is their skin very fragile or do they have a diagnosis that causes spontaneous bruising such as Pemphigus, where the individuals body reacts as if it is a foreign object, One other cause of bruising is the use of Predisone. Also if the resident had a recent hospitalization or blood draw or the resident had a recent fall which was witnessed by another individual;in regards to laceration if the individual had very thin skin	06/17/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the unit supervisor and charge nurse." "2... b. "...report the incident verbally to a supervisor immediately. c. Document the suspected abuse as requested by the Director of Nursing or Administrator within 24 hours...." "3. Any Unit supervisor or charge nurse receiving an allegation of suspected abuse or neglect must report the incident or information immediately to the Director of Nursing or the Administrator. The Unit supervisor or charge nurse shall document all known facts surrounding the incident or injury and provide his/her written report to the Director of Nursing or the Administrator." The section entitled, "Identification and Reporting or Suspected Abuse, Neglect and Mistreatment" indicated the following: "1. All of the following are examples of possible abuse, neglect or mistreatment and must be reported immediately to the Unit Supervisor and charge nurse.... b. Any significant unexplained bruise, cut or other wound....." And, the section titled "Inservice on Identification, Reporting and Investigation of Suspected Abuse, Neglect or Mistreatment of Residents" indicated, "Report immediately any		due to increased age. The revised policy of July 2009 qualifies the fact that not all contusions or lacerations are reported since the individual could have circumstances that could cause the bruising. Yes it is our policy that all injuries of unknown etiology are reported to the DON. The DON is part of the committee that reviews the injury and along with the Administrator and Unit Co-Ordinator decide whether this is a reportable injury or is it a result of a medical condition or medication related. When the falls are reviewed at the QA meeting injuries of unknown origin are noted and whether these were reported to the state or not. The fall investigation sheet helps also to determine whether the injury was such that it should be reported to the state and what can be done in the future to prevent further injury.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incident of abuse to the Unit Supervisor, Charge Nurse, and/or Director of Nursing." During an interview on 5/19/11 at 2:30 p.m., the Director of Nursing indicated the Administrator is notified immediately of allegations, along with the Unit Supervisor and herself. The Director of Nursing indicated there have been no allegations of abuse, neglect or mistreatment or any reportable incident to the Indiana State Department of Health since the last annual survey. During the same interview, the Director of Nursing was asked at what point a contusion or laceration would be considered large or significant enough to report and investigate. The Director of Nursing indicated the bruise doesn't have to be certain size to investigate, and she doesn't think the policy specifies this, but will look. On 5/20/11 at 8:30 a.m., the Director of Nursing provided the "Policy Statement Reporting Unusual Occurrences," dated as revised on 7/2009. Review of this policy indicated the following: "Injuries of Unknown Source" "An injury should be classified as an injury of unknown source when both of the following conditions are met:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Source of the injury was not observed by any person and the resident could not explain the injury... 3. Large areas of contusions or lacerations on an individual who is not on blood thinning medication or does not have very thin skin...." The policy did not define how large a contusion or laceration would be in order to be investigated and reported. The Indiana State Department of Health Division of Long Term Care policy and procedure for Reportable Unusual Occurrences, dated 11/15/97, revised 1/25/2006, indicates under "Significant injuries," "Large areas of contusions or large lacerations as defined in facility policy." 3.1-28(a)			
F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure severely cognitively impaired residents were provided opportunities to attend activities for 2 of 3 residents reviewed for activities in a sample of 9	F0248	The activity Progress dated 3/8/2011 indicated that RT may try some exercises in the afternoon. In this case RT stood for Restorative Therapy. RCNA will be sure that all residents who have orders for Restorative	06/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	who met the criteria for activities (Residents # 42, #32). Findings include: A current facility policy dated 7/2005 and titled "Activities" and provided by the Director of Nursing on 5/20/11 at 10:00 A.M. indicated, "Policy: The Home will provide social ... activities. Purpose: ... To encourage Resident participation in social ... activities." 1. The record for Resident # 42 was reviewed on 5/18/11 at 9:00 A.M. Diagnoses for Resident # 42 included but were not limited to, dementia, depression, Parkinson's disease, idiopathic peripheral neuropathy, hypertension and diabetes. An Activity Progress Note dated 3/8/11 indicated "...Recreational Therapy (RT) may try some exercises in the afternoon." Resident # 42 was observed on the following dates and times: 5/16/11 at 11:55 A.M. the resident was observed in the dining room for lunch. 2:00 P.M. the resident was sitting in the TV lounge.		services have their flow sheets and that documentation is noted on each. As for the activities we will draw up new forms that will document the time spent by volunteers and family members interacting with the cognitively impaired as well as with the other residents. The new forms will become part of the Resident's chart. We will start using these forms on June 20th and enlisted our volunteers aid. Currently we have volunteers who will play their musical instrument for the resident on a 1 to 1 basis in their room. Family members as well as volunteers take them to the Cafe and also outdoors. As for the 1/2 tray on resident #32 a glass of liquid can be put on the tray and she will take small drinks. Also if you give her a magazine with recipes and pictures she will respond as long as her agitation is not severe at the moment. The Psychiatrist noted that due to overall mental condition at times her agitation is severe. Resident #32 is 100 years old and will respond when talking about cooking. Activity Assistant according to her notes of 4-19-2011 did not say the tray was a restraint She stated that it was not only for activities. A LPN on the evening shift would not be here when Mass is held. It will be documented if the residents is disruptive and needs to be removed from the Chapel. To ensure this the Nurse who does	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/17/11 at 9:00 A.M. the resident was observed sitting in the TV lounge. 10:30 A.M. the resident was observed sitting in the TV lounge. 12:45 P.M. the resident was observed sitting in the TV lounge. 5/18/11 at 9:00 A.M. the resident was observed sitting in the TV lounge. 1:30 P.M. the resident was observed in bed. During an interview with the Restorative CNA (RCNA) #6 on 5/18/11 at 1:45 P.M., she indicated the resident attends RT three times per week on Monday, Wednesday and Friday for 10 minutes a day. RCNA #6 indicated there was a flow sheet (treatment record) to track the times the resident attends RT, but there was not one for May. RCNA #6 indicated the resident had not been to RT in the month of May and didn't know why. RCNA #6 indicated if there is a flow sheet for April, it would be in the chart under ADLs (activities of daily living). Documentation as to why the resident did not attend RT should be written on the back of treatment record. The April flow sheet lacked documentation the resident attended		our fall Assessments will check to see that the forms are completed. The audit will beweekly for the first two weeks and then monthly for three months. The MDS Co-Ordinator will assure that an activity plan was initiated for each resident. In using new Forms in order to better meet the needs of the cognitively impaired it is our goal to meet each resident needs bringing them to the highest practical level. Also the policy concerning activities and nursing will be posted on the unit for a better cooperation between both departments. At each care plan the records for the individual will be reviewed to see that the goal is met and if not why not. We will use volunteers to help us meet the Residents needs and in a special way have them document what they do. The Resident's chart will contain this documentation at the end of each month. Our Fall Assessment Nurse will audit the records for the cognitively impaired every two weeks for six weeks then monthly for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	RT on the following dates: April 8, 11, 13, 18, 20, 22/2011. The back of the flow sheet lacked documentation as to why the resident did not attend RT for those days. During an interview with the Activities Assistant #2 on 5/18/11 @ 2:30 P.M. she indicated the resident does not always participate; he watches more than participates. There have been 1 on 1 visitation with the resident on 5/2, 6, 9, and 16th, but the resident was asleep at those times. Everyone is scheduled a general visit in the morning, but he is usually asleep. 2. Resident #32's record was reviewed on 05/19/2011 at 9:30 AM. Diagnoses included, but were not limited to, dementia, anxiety, hypertension, and heart failure The MDS (Minimum Data Set) assessment, dated 04/13/2011, indicated resident had severe cognitive impairment A physician's order dated 04/15/2011 indicated the resident was to have a tray on wheelchair to provide resident area for sensory stimulation, i.e.: snacks, books, magazines, familiar objects which improved her comfort and to provide resident area to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	restti arms." An acttivittiy progress notties ftor ttihe observattion period 04/07/2011 - 04/13/2011 indicattied residentti #32 "...occasionally she [sic] will attiend a group acttivittiy ift ttihere is an aide available who can sttiay wittih her ttihe whole ttime." An acttivittiy progress nottie dattied 10/26/2010 indicattied residentti used ttio crochetti "and ttihe acttivitties sttiaft will ttiry wittih residentti ttio encourage and help ttio crochetti A social services progress nottie dattied 04/19/2011 indicattied residentti has ttirouble concenttiratting and declines going ttio mass A currentti care plan dattied 04/19/2011 indicattied ttihe residentti has a decreased inttierestti in doing acttivitties residentti becomes agittiattied in group settings Inttierventtions included "...acttivittiy sttiaft or volunttieer ttio ttiransportti residentti ttio and ftrom acttivitties and sttiay wittih her during acttivittiy ttio make her fteel more comftorttiable encourage residentti ttio attiend acttivitties oft her choice and ttio praise residentti ftor partticipattion in acttivitties A currentti care plan dattied 04/19/2011 indicattied ttihe residentti has fteelings oft sadness			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and verbalizattions oft loneliness Inttierventtions included "...attiemptti ttio inttierestti residentti in acttivitties ttio keep ttheir [sic] mind oft oft depressed fteelings, encourage residentti ttio attiend mass ftor spirittiual suppo..rt."tti Residentt #32 was observed on 05/16/2011 atti 10:15 AM and 1:00 PM, 05/17/2011 att 8:30 AM and 2:40 AM, and 5/19/2011 atti 10:45 AM and 3:30 PM wittih ttihe 1/2 tray ttiable up on ttihe wheelchair. The residentti was restting her arm on ttihe ttiray. There were no ittiems or sensory sttimulattion objecttis observed on ttihe ttiray. The residentti was sitting in ttihe TV room wattiching ttielevision Residentt #32 was observed on 05/17/2011 atti 10:40 AM, sleeping in ttihe TV room Rosary services were occurring in ttihe chapel atti ttihis ttime. The services were notti being ttielevised on ttihe TV. An inttierview wittih acttivitties assistta#2 nti 05/19/2011 att 9:45 AM indicattied residentti enjoys attiending some group acttivitties, such as exercise and sing alongs butti does notti partticipattie. Residentti gettis very anxious ift she does notti have someone sitting nextti ttio her atti ttihe group acttivitties. Acttivitties assisttia#2 ti indicattied ttihe residentti enjoys attiending mass butti is often unable due ttio her anxiettie. Thhe			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assisttiantti indicattied ift a residentti cannotti attiend mass ttihey can wattich ttihe services on TV. The acttivitties assisttiantti indicattied ttihey do notti provide residentti #32 wittih sensory sttimulattion ittiems because "...ttihatti is notti ttihe purpose oft ttihe ttiray ttiy is ftor a resttiraintti ftor objecttis." and ttihere arentti any scheduled 1:1 acttivitties wittih ttihe residentti because "...ttihe sttiaft handle ttihatti on ttihe unitti...." An inttierview wittih LPN #4 on 05/19/2011 atti 4:15 PM indicattied residentti #32 is unable ttio attiend services as she is ttioo disrupttive When she gettis anxious, ttihe sttiaft ttiry ttio keep her moving in ttihe wheelchair. 3.1-33(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, interview and record review, the facility failed to ensure an accurate assessment for positioning was completed for 1 of 11 residents reviewed for assessments in a stage 2 sample of 11. (#10) Findings include: The record for Resident #10 was	F0272	The Occupational Therapist notified us that it is no longer the resposibility of their Department to measure or recommend positioning in Wheelchairs. The therapy department gave us the name of a Mr. Kerry Marschand CAPS, ATP of United Seating and Mobility. When the gentleman arrived he stated that he had measure resident #10 in 2006 and she was given a wheelchair	06/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed on 05/18/11 at 9:15 a.m. Diagnoses for Resident #10, included, but were not limited to, coronary artery disease, hypertension, osteoporosis, seizure disorder, and depression. The most recent annual Minimum Data Set (MDS) assessment, dated 03/09/11, indicated, Resident #10 was cognitively able to report correct year, correct month, correct day of the week. Resident #10 was able to recall sock and blue with no cueing and able to recall bed with cueing. The most recent annual MDS assessment, dated 03/09/11, indicated Resident #10 needed limited assistance for bed mobility, walking and dressing. MDS indicated, resident was able to transfer from seated position to standing unsteady, but able to stabilize without person physically assisting. The MDS indicated Resident #10 uses a walker and wheelchair. Range of Motion section was marked as no issues. Resident #10's height was recorded as 62 inches and her weight was recorded as 98 pounds. A care plan for Pain, dated as		which she felt very insecure with and therefore did not utilized it. After discussion with resident and her daughter it was decided to fit one of the motorized wheelchair that the facility had on hand so she would have improved mobility. The arm rest on her other chair were cut down. The note from Activities for 3-15-2011 was correct but at that time the Resident refused a new Wheelchair. On May 19, 2011 another attempt was made to have the resident use another wheelchair. She took the one offered to her went up the hall once and then down and stated my own is better. When the resident came to the facility from another facility that was the wheelchair she came in. She was asked if at least the arm rest could be switched so she could reach the wheels better and she absolutely refused. If she then refuses a note will be made both by the Therapist and the nurse. An attempt was made by her daughter on 6-6-2011 to have her Mother try another wheelchair. The Resident refused because she felt it was not strong enough to support her when she transfers. The Resident does transfer her self without any apparent difficulty. Proper documentation will be made by all involved. In order to avoid this confusion in the future any resident who is received in the facility in a wheelchair will have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	originated on 4/19/10 and still current, indicated Resident #10 has the potential for pain related to arthritis and scoliosis. Interventions included, but were not limited to, asses pain level, pain medication as ordered and non medicinal methods of relief, for example relaxation, imagery and music. A care plan for Activities of Daily Living (ADLs), dated as originated on 4/19/10 and still current, indicated interventions included, but were not limited to, refer resident to therapy if decline in abilities noted, set up supplies, cue, break task into subtasks, assist as needed, and praise. The most current Recapitulation dated 04/28/11, indicated, "...may be seen by O/T (occupational therapy), P/T (physical therapy), & S/T (speech therapy) as needed...." An Activity Progress Note dated 03/15/11, indicated, "...Resident is not participating in any PT/RT [Restorative Therapy] at this time, but she may be getting a new wheelchair...." A Physician's Progress Note, dated 05/13/11, at 1800 (6:00 p.m.),		an assessment to figure out if they are in the proper chair. This will be monitored by the ADON and the individual filling out the assessment will be a LPN. If the assessment done indicates that the resident is in need of further evaluation and correction of the posture of the existing wheelchair United Seating and Mobility will be notified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, "...sitting in wheelchair - marked kyphoscoliosis...I think a lot of her sxs (symptoms) are due to posture/ kyphosis [and] will be difficult to improve...." During a dining observation on 5/16/11, at the lunch time meal, Resident #10 was observed with her chin at table level related to her positioning in the wheelchair. During an interview with Resident #10, on 5/18/11, at 9:00 a.m., the resident indicated her wheelchair was too big. "Ya see, I'm short." Resident indicated she has had this wheelchair for a long time. During an observation, on 05/18/11, at 9:07 a.m., Resident #10 stood at the bedside and transferred self from wheelchair to bed. During an observation, on 5/18/11, at 4:00 p.m., the resident propelled self in the wheelchair down hall toward her room. **During an observation, on 5/19/11, at 12:56 p.m., Resident #10 was observed propelling self in wheelchair with her arms from the shoulder to the elbow with the**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	positioning parallel to the floor. An interview with RCNA (Restorative Certified Nurse Aide), on 5/19/11 at 10:31 a.m., indicated Resident #10 had been discharged from PT on 5/24/10 to ambulate with staff. RCNA indicated Resident #10 was not being seen for positioning, assistive devices or wheelchair issues. During an interview with LPN #7, on 5/19/11 at 2:22 p.m., LPN #7 indicated Resident #10 leans over in posture because of her back, even when ambulating. During an interview with the ADON, on 5/19/11 at 2:25 p.m., she indicated the wheelchair positioning, "Its not the best." She indicated there had not been an assessment from PT or OT. The record lacked documentation of an assessment for positioning and positioning related to the wheelchair. The record lacked documentation of an assessment for the proper size wheelchair. 3.1-31(c)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure a care plan was developed for activities for 1 of 11 residents reviewed for care plans in the stage 2 sample of 11 (Resident #42). Findings include: The record for Resident # 42 was reviewed on 5/18/11 at 9:00 A.M. Diagnoses for Resident # 42 included, but were not limited to, dementia, depression, Parkinson's disease, idiopathic peripheral neuropathy, hypertension and diabetes.	F0279	All care plans will be printed as soon as possible after the care plan meeting noting any recommendation brought up at the meeting. An audit will be made one week after the care plan meeting by the Fall Assessment Nurse. The MDS Co-Ordinator is the one responsible to ensure that care plans are complete and accurate. Our Medical Record Consultant will audit care plans every month times three and then every quarter. If an issue arose that was on a regular basis at that time it would be brought up in the Quality Assurance Meeting.	06/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Review of the Activity Assessment completed on admission indicated the resident enjoys TV, especially game shows.
Documentation from the 10/5/10 Care Plan meeting indicated the family indicated the resident is not social but may enjoy observing performances.
Documentation from the 3/8/11 Care Plan conference indicated PT (physical therapy) would like to work with the resident on standing and mobility but is only available in the morning, and the resident is too sleepy at that time of day. Family expressed that this has always been the resident's pattern. RT (restorative therapy) to try exercises in afternoon.

An Activity Progress Note dated 3/8/11 indicated "...Recreational Therapy (RT) may try some exercises in the afternoon."

Review of care plans indicated a 10/20/10 care plan for insomnia, and a care plan for depression, dated 10/2/10 & updated 3/3/11, which indicated to attempt to interest resident in activities to keep mind off of depressed feelings.
The record for Resident # 42 lacked documentation of a care plan for activities.

During an interview with the MDS (minimum data set assessment) Coordinator on 5/20/11 at 8:30 A.M., she indicated there was not a care plan for activities for Resident # 42.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-35(a)			
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review and interview, the facility failed to ensure a resident received necessary bathing assistance to meet the resident's needs and preferences, for 1 of 15 residents interviewed in the stage 1 sample of 36 (Resident #37). Findings include: During interview with resident #37 on 5/16/11 at 11:35 a.m., the resident indicated, "I used to get waited on and baths and now they are neglecting me. I haven't had a bath in a month. They listen but it don't do much good." Review of the bath schedule, on 5/18/11 at 10:30 a.m., for the unit the resident resided on, indicated the resident was scheduled for baths on Mondays and Thursdays, day shift. During an additional interview with the	F0312	Resident #37 is again Hospitalized when the individual returns to the facility he will be offered a bath twice a week as requested. If for some reason the bath was not given on the assigned day this should be reported to the nurse and note made in the chart. The only reasons a bath should not be given on assigned day is if the Resident is ill or requests another day. A note will be given to the CNA'S so they can follow procedure. If a resident should refuse a bath the nurse will be notified and the nurse would approach the resident and see if they can encourage them to bath. The logs for the shower sheets which are audited by the medical secretary will be give to the Sister in charge of the unit. It will be noted on this sheet if there is a tendency on the part of a CNA just to write refused. This will be brought to the Sister on the unit so it can be corrected. All shower sheets and the audit is kept in the medical secretary's	06/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident on 5/18/11 at 10:55 a.m., the resident said he still has not had a bath, and did not remember having a bath on Monday (5/16/11). He indicated he has told the nurse/aides that he wants a bath, but he has not had one. Review of bathing record for May 2011, on 5/18/11 at 12:50 p.m., indicated a tub bath was documented on 5/16/11 (Monday). Bed baths were documented on other days. No showers or tub baths were documented on any other date in May. On 5/18/11 at 1:40 p.m., LPN #1 provided a Bath/Shower Day Body Check form, from 4/28/11 (Thursday), which indicated a tub bath was given and hair was washed. LPN #1 said there was no other bath/shower documentation from 4/18 through 4/29/11 for resident #37. The resident should have received a tub bath or shower on 4/21 and 4/25/11, according to the bath schedule. Resident #37's record was reviewed on 5/18/11 at 8:45 a.m. The record indicated the resident was admitted on 4/18/11, and was hospitalized on 4/29 through 5/04/11 and again on 5/09 through 5/13/11. The MDS (Minimum Data Set)		office.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 4/27/11, indicated the resident's cognition was intact, and the interview for daily preferences indicated it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. The assessment indicated the resident required limited assistance with one staff person for transfers, walking in room, dressing, toilet use and personal hygiene, and needed physical help with bathing. During interview on 5/19/11 at 8:55 a.m., the CNA (#9) assigned to the resident indicated she gave the resident a tub bath today, and he was able to help wash his face, arms, and private area, and was cooperative with care. The CNA indicated before, between hospitalizations, he did need more help. The CNA indicated she wasn't here on Monday (5/16/11) when his last tub bath was documented. **3.1-38(a)(3)**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure mattresses fit properly on the beds, related to observed gaps (larger than 4 3/4 inches) between the mattresses and footboards, which increases the risk for potential entrapment, for 3 of 36 residents in the facility. (Residents #4, #9, #36) Findings include: 1. Resident #9's record was reviewed on 05/18/2011 at 9:30 AM. Diagnoses included, but were not limited to, hypertension, aphasia, and stroke. A current MDS (minimum data set) assessment, dated 05/04/2011, indicated the resident had severe cognitive impairment. A current care plan, dated 05/10/2011, indicated the resident had alterations in long and short term memory. Observation of the resident's room on 05/17/2011 at 4:30 PM indicated the	F0323	For Resident 36, 9 and 4 bolsters were put on the bed for safety on 5-17-2011 and mattresses were brought up on 5-18-2011. In order to prevent this from happening in the future all new mattresses ordered will measure 80inches in length. The medical secretary will keep the invoices to prove the length. The unit supervisors will be the ones to monitor the mattress length and this would be done only when a new mattress was acquired or a resident asked to have their mattress changed. The monitoring would be noted in the nurses notes on the resident's chart.	06/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	gap at the foot of the bed between the mattress and foot board was noted to be 6 1/2 inches. 2. Resident #4's record was reviewed on 05/18/2011 at 11:20 AM. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, and osteoarthritis. A current side rail evaluation form, dated 03/23/2011, indicated the resident required use of 1/2 upper side rails because "...resident is not aware of edges of bed [sic]." A current MDS assessment, dated 03/23/2011, indicated the resident was severely cognitively impaired and never or rarely was able to make decisions. A current care plan, dated 03/25/2011, indicated the resident had an alteration in her short and long term memory and required two upper 1/2 side rails "...due to cognitive loss and no awareness of the edges of the bed...." The care plan indicated the resident has a "potential for injury related to severe cognitive impairment and no awareness of what may be harmful."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Observation of the resident's room on 05/17/2011 at 4:30 PM indicated resident was lying in the bed on her right side. The gap at the foot of the bed between the mattress and foot board was noted to be 7 1/2 inches. An interview with LPN #5 on 05/18/2011 at 1:15 PM indicated the resident is unable to get out of bed on her own and the only way she could get out is if she rolled out of bed. 3. The record for Resident # 36 was reviewed on 05/18/11 at 2:00 p.m. Diagnoses included, but were not limited to, osteoporosis, hypertension and dementia. The most current annual Minimum Data Set (MDS) assessment on 02/16/11 indicated, Resident #36 had a cognitive orientation that resident knew the correct year, correct month, but the incorrect day of the week. Resident #36 was able to recall the words sock and blue without cueing, and was able to recall the word bed with cue. Functional Status indicated resident needed limited assistance for bed mobility and extensive assistance for transfer.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A care plan for falls, originally dated 04/09/10 and still current, indicated interventions included, but were not limited to, remind resident to call for assistance when wanting to transfer. A restorative Nursing Progress Note, dated 11/30/10 at 10:05 a.m., indicated the resident cannot ambulate alone because of unsteady gait. During an observation on 05/17/11 at 2:32 p.m., the resident's bed was observed with a large gap between the mattress and the footboard. On 05/17/11, at 4:30 p.m., the gap at the end of the bed between the mattress and the footboard was measured as 7 inches. During an interview with the DON, on 05/17/11 at 5:30 p.m., the DON indicated she was not aware of the gaps and would fix the problem. She indicated the mattresses and beds had been ordered by the same bed company. The Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment-Guidance for Industry and FDA Staff issued March 10, 2006			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicates the following: The " Hospital Bed Safety WorkGroup (HBSW) " and the " International Electrotechnical Commission (IEC) " along with the FDA recommend spaces be less than 4 ¾ inches to prevent the head from entering or being entrapped. 3.1-45(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0334 SS=C	The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on record review and interview, the facility failed to ensure annual consents for influenza vaccinations were obtained prior to administration of annual flu vaccines for 4 of 5 residents reviewed for flu vaccination consents, out of the facility census of 36 residents (Residents #16, #21, #15, #4). Findings include: A current facility policy, dated 7/2005, titled "Influenza Vaccine", provided by the Director of Nursing on 5/16/11 at 2:00 P.M. indicated: "Policy All residents who wish to be vaccinated are vaccinated	F0334	Following the advice of a surveyor approximately six years ago we took the practice of having the permission signed once with stipulation for yearly vaccination. In order to have current permission we will have the family or resident sign at their care conference. This will ensure that we have yearly permission. If an individual does not have a family member present at any of their care conference the form will be mailed to them by the month of September. No vaccine will be given without this signed permission. The ADON has the responsibilty to see that this is accomplished. She will keepa log showing who signed the permission and who did not.	06/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	annually...." The policy lacked documentation regarding getting consents annually prior to immunizations. On 5/18/11 at 4:00 P.M., the following records were reviewed for flu and pneumonia vaccinations and consents: 1. Resident #16, consent was signed 11/1/06, the last flu vaccine was administered on 10/12/10. 2. Resident #21, consent was signed in 2009, the last flu vaccine was administered on 10/11/10. 3. Resident #15, flu vaccine was administered on 10/21/10, the record lacked a signed consent. 4. Resident #4, consent was signed on 11/6/06, the last flu vaccine was administered on 10/12/10. During an interview with RN #3 on 5/19/11 at 2:30 P.M., she indicated an initial consent for flu vaccination is obtained, but they have not been getting a new consent form signed annually. 3.1-13(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and record review, the facility failed to ensure the staffing information was properly completed and prominently displayed. This had the potential to affect all 36 residents residing in the facility and their visitors.	F0356	To the existing staffing form the FTE hours and fulltime hours were noted as well as the census and name of the unit.	06/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: During observation of the staffing on 05/16/2011, 05/17/2011, 05/18/2011. and 05/19/2011 on the 2nd and 3rd floor, the staffing posted lacked documentation of the daily census, and the actual hours worked by both licensed and unlicensed nursing staff. The staffing was located on each floor in a binder on the nurses station titled, "Report of staff directly responsible for nursing care, CNA assignments" During the environmental tour on 05/19/2011 at 2:45 PM, a sign was located on the 2nd floor indicating that staffing could be located in a binder at the nurses station. There was no sign located on the 3rd floor indicating the location of the posted staffing. 3.1 13(g)(1)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was properly stored and labeled in the refrigerator. This had the potential to affect 34	F0371	To ensure that all foods are appropriately marked we have ordered stickers that state the day and the only thing the individual needs to mark is the date and	06/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents who received food from the kitchen in the census of 36. Findings include: During the initial kitchen tour on 5/16/11 at 9:30 a.m., three opened half gallons of milk, one deli plate with lunchmeat and cheese and two plates of sliced peaches were observed in the walk-in refrigerator without a date indicating when the items were opened or prepared. During interview at this time, the Dietary Manager indicated these items should have been dated. 3.1-21(i)(3)		their initial. This will be monitored every shift times two weeks, then daily with alternating shifts for two weeks and then then weekly times two weeks and then monthly for 3 months. Then random inspections. The labels have been ordered as of June 3rd, 2011. The Dietary manager herself or another designated by her will keep the log. An in-service will be given and it will be mandatory for kitchen staff. Results of this audit will be given to the medical secretary, who if their is difficulty will notify the Dietary Manager and then at the Quality Assurance Meeting bring the subject up asking for any suggestions on how to correct it.	